ShelterCare®
PET INSURANCE PROGRAMS
Underwritten by Praetorian Insurance Company, NY

# Gift Claim Form

**INSTRUCTIONS:** Please complete ALL sections on this form and submit with your paid itemized invoice and pet's medical history. Only one claim form per pet. A new completed claim form is required with every claim submission. A complete veterinary medical history (records) from both current and previous veterinary clinics is required to process your pet's first claim. Follow the Claims Checklist to avoid delays in processing.

## Claims Checklist

- ☐ **Complete Section 1 About You and Your Pet**
  - ☐ Include your Policy Number and Contact Information
- ☐ Review your Policy Documents and Terms and Conditions regarding available coverage and limits applicable to your policy
- ☐ Have the treating veterinarian complete Sections 2, 4 and 3 if applicable.
- ☐ Complete Section 3 Payment Details
- ☐ Sign your claim form in Section 4: Declarations
- ☐ Attach detailed paid invoices for condition(s) you are claiming for

**Missing information, signatures, or required supporting documents will result in delays in processing your claim*

**Medical Records Include:**
- ☐ Detailed examination or SOAP notes
- ☐ Lab/pathology/radiology reports
- ☐ Medical reports from referral or emergency hospitals

*Transaction histories and invoices are not accepted*

**Invoices Must Be:**
- ☐ Detailed and Itemized indicating the cost and treatment
- ☐ Paid, unless reimbursement is to be made and agreed to by the veterinarian *Account Summaries are not accepted*

## SECTION 1A: Your Pet's Information

**Policy Number:**

**Pet Name:**

**Species:** ☐ Dog ☐ Cat **Breed:**

**Age:**

## SECTION 1B: Your Information

**Your Name:**

**Mailing Address:**

**Email Address:**

**Home Number:** **Cell Number:**

☐ Check here if there has been a change to your address or phone number

## SECTION 2: About Your Claim To be completed by the treating licensed Veterinarian

**Please indicate the named accident or illness which was diagnosed and treated (coverage is available for these conditions only):**

- ☐ Foreign Body Ingestion Removal by Endoscopy or Laparotomy
- ☐ Upper Respiratory Tract Infection
- ☐ Urinary Tract Infection (including FLUTD)
- ☐ Defined Poison Ingestion (specify): _____
- ☐ Intestinal Parasites (specify): _____
- ☐ Eye Illness (specify): _____
- ☐ Motor Vehicle Accident
- ☐ Heartworm Disease
- ☐ Ear Illness (specify): _____
- ☐ Mange/Mites/Ringworm
- ☐ Parvovirus/Feline Panleukopenia
- ☐ Flea Allergy Dermatitis
- ☐ Tick Borne Diseases
- ☐ Insect Bites/Stings
- ☐ Lacerations
- ☐ Bone Fractures

**Date accident occurred or symptoms of illness were first noted:** ____ | ____ | ____
MM DD YY

**Comments:**

## SECTION 3: Optional Direct Deposit Payment Details

**PLEASE MAKE DIRECT PAYMENT TO** (select one)**:**

☐ **Policy Holder** ☐ **Veterinarian/Veterinary Clinic**

- For payment to be made directly to the veterinary clinic, a completed Pay to Clinic form is required.
- The selected party must enter their bank details in the section below to receive a direct deposit regardless of whether they match those used for billing of premiums.
- If direct deposit details have not been received and/or if a direct deposit payment is unsuccessful, a check for all payable treatment expenses will be sent via regular postal service.
- Note: direct deposit payment is independent from premium billing and will not affect your method of payment for policy premiums.

**Name of Account Holder:** **Name of Bank:**

**Account Number:** **Routing Number:**

Please select one from the following options:

☐ I authorize present and future claim reimbursements to be deposited into the above account when Direct Deposit has been selected.

☐ I have previously provided my banking information. I authorize eligible claims reimbursement to be deposited into this bank account.

☐ Provide claim reimbursement in the form of a check.

## SECTION 4: Declarations

### Policyholder Declaration

I declare that my veterinarian recommended the treatment for which I am claiming. The veterinary clinic has completed Section 2 and the particulars given are correct to the best of my knowledge and belief. I agree that my veterinarian may provide information that the company may require to verify a claim. I understand that any misrepresentation or omission of any material fact can result in denial of the claim.

**Signature of Policyholder**

Date: _____ | _____ | _____
**MM** **DD** **YY**

### Veterinarian Declaration

I declare that diagnosis and particulars given in Section 2 in regards to the treatment of this pet are correct to the best of my knowledge and belief. I agree to provide information that the company may require to verify a claim. I understand that any misrepresentation or omission of any material fact can result in denial of the claim.

**Signature of Veterinarian**

Print Veterinarian Name:

Date: _____ | _____ | _____
**MM** **DD** **YY**

### Please submit completed claims by:

**Mail**
P.O. Box 2150
Buffalo, NY 14240-2150

**Email**
medicals@pethealthinc.com

**Fax**
1.866.369.7387

**Questions:**
Call our Customer Care Unit at
1.877.291.1524

**CLINIC STAMP**

**Applicable in Arizona**
For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
**Applicable in Arkansas, District Of Columbia, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, Pennsylvania, Tennessee, Virginia and West Virginia**
Any person who knowingly and with intent to defraud any insurance company or another person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties. In DC, LA, ME, TN and VA insurance benefits may also be denied.
**Applicable in California**
For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
**Applicable in Colorado**
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulator y Agencies.
**Applicable in Delaware, Florida and Idaho**
Any person who knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company Files a Statement of Claim Containing any False, Incomplete or Misleading is Guilty of a Felony. *
*In Florida – Third Degree Felony
**Applicable in Hawaii**
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
**Applicable in Indiana**
A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
**Applicable in Minnesota**
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
**Applicable in Nevada**
Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.
**Applicable in New Hampshire**
Any person who, with the purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
**Applicable in New York**
Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who in connection with such application or claim knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false repor t of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the Department of Motor Vehicles or an insurance company, commits fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.
**Applicable in Ohio**
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
**Applicable in Oklahoma**
WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
**In the state of WA and all other states not mentioned above and Puerto Rico;** it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.